AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NIMC Local Management Guidelines

June 2013

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Introduction

The NIMC is a suite of nationally standard medication charts, both paper and electronic, that present and communicate information consistently between healthcare professionals providing care to patients on the intended use of medicines for an individual patient.

Its purpose is to reduce the risk of prescribing, dispensing and administration error by health professionals through standardised presentation of information on the intended use of medicines for an individual patient, and through standardised presentation of medicines information in all high risk healthcare settings.

NIMC use is a mandated requirement for accreditation. Health service organisations seeking accreditation against National Safety and Quality Health Service Standard 4 Medication Safety must demonstrate use of the NIMC.

The requirement on health service organisations is to use relevant NIMCs which have been agreed nationally and which incorporate the NIMC elements and layouts. Electronic medication management systems are required to incorporate the full range of NIMC safety features as a minimum.

Non-conforming medication charts:

- will not be verifiable for accreditation purposes
- cannot be audited through use of the NIMC Audit System
- are not reflected in any nationally maintained support materials including education resources
- may create medico-legal risks for health service organisations in the event of patient harm related to medication misadventure.

Managing the NIMC locally

The NIMC can be managed locally by health service organisations. The NIMC Local Management Guidelines provide detailed guidance on the scope of changes to the NIMC which can be authorised at local levels (i.e. state / territory, private health service chain / local hospital network and individual health service organisation). It describes the process for managing NIMC issues which cannot be managed locally and which need to be referred to the national level for consideration. The NIMC Local Management Guidelines are available electronically at www.safetyandquality.gov.au/wp-content/uploads/2012/02/NIMC-Local-Management-Guidelines12.pdf

1. Permitted NIMC local alterations

The overarching principle is that layout of the NIMC is not to be altered.

Table 1: Summary of NIMC sections that can or cannot be changed

NIMC sections that cannot be altered	NIMC sections that can be altered
Patient identification	The logo
Chart numbering	Recommended administration times
Allergies and adverse drug reaction alerts	A coloured strip may be added to the NIMC to assist with rapid chart identification
Once only, pre-medication orders and nurse initiated medicines	A medical record number or bar code may be added
Telephone orders	The number of days for administration
Medicines taken prior to presentation to hospital (where a facility has a dedicated medicine reconciliation form, a note should be made in this section to refer to the alternate form)	The list of additional charts may be increased
Format for documenting regular medicines	The general colours used on the chart, except for the sections highlighted in red.
Patient weight and height	Discharge supply (where PBS discharge prescriptions are used or other local regulatory requirements are in place)
Format for documenting PRN medications	

Table 2: General principles for use of the NIMC

Principle	Rationale
Generic name	This is to minimise the risk of the same medicine being prescribed twice, through lack of familiarity with different brand names. In addition medicines are usually stored alphabetically according to generic name and are therefore easier to find if prescribed generically. Specified exceptions may be authorised locally (e.g. for combination products or 'look-alike' / 'sound-alike' products).
Sequencing	The sequence, drug, route, dose and frequency, encourages prescribers to consider the correct dose in relation to the route prescribed, for example ranitidine iv 50mg three times daily or ranitidine orally 150mg twice daily.
Prescriber name and contact details	The prescriber must be clearly identifiable to minimise delays in clarifying the order when required. Some prescribers will enter a pager number, whilst others will enter a prescriber number, in accordance with local policies.
Abbreviations	Abbreviations are discouraged, as they may lead to misunderstandings. A number of abbreviations are particularly error-prone and these should be prohibited.

Table 3: Sections of the NIMC that may be altered by local agreement

Section	Rationale
Logo	Insertion of the hospital logo will assist in identification of the origin of the chart.
Administration times	These may be adapted to be consistent with local practice. Feedback has indicated that standardisation of local administration times and targeted education supports medical staff in their role of completing administration times.
Coloured strip	This may be added to the side margin to assist in identifying the NIMC when filed in the case notes.
Medical record number or bar code	This may be added to assist with identification and ordering of medication charts, in accordance with local hospital information service requirements.
Ancillary charts	The list of ancillary charts may be amended to suit local needs. It is acknowledged that fewer charts will reduce the risk of prescribing and administration error.
Colours	Red, black and grey have been used to alert and differentiate between sections of the chart. These colours may be varied, however, it is recommended that consideration be given to legibility after faxing and printing to ensure that safety is not compromised. Use of additional colours may generate additional printing costs.
Number of days	The number of days for administration may be adjusted to meet local requirements. The need for transcription should be minimised as this can increase medication error.
Copies	Opportunities for error in interpretation exist with use of carbon copies instead of original orders. Local procedures should ensure that carbon copies are not used as the primary reference document for dispensing or administration.
Discharge medicine section	A section has been included on the chart to minimise the risk of transcription errors for discharge medicines. For each medicines, the prescriber should indicate whether discharge supply is required, including the duration/quantity. Prescribers must provide their signature, printed name and the date the discharge medicine is ordered. The pharmacist should ensure the discharge information is complete and also sign and date this section. When there is a change in dose for a discharge medicine, a new order should be written, the discharge section completed and the administration section crossed out. Jurisdictions can agree to remove the discharge medicine section if they • use the Pharmaceutical Benefits Scheme for discharge prescriptions; • or where local regulatory requirements for separate discharge prescriptions exist.
Binding margin	The binding margin for the NIMC is located in the middle and for the NIMC long-stay on the left. Jurisdictions may choose to bind all medication charts from the left side.

Table 4: Sections of the NIMC that must not be altered without national approval

Section	Rationale
Patient identification	Either a patient identification label should be attached, or the patient's name, date of birth, gender and unit record number must be printed legibly. If an identification label is used, the first prescriber must print the patient's full name by hand under the label, to reduce the risk of ordering for the wrong patient. Writing the patient's name is in addition to attaching a label and acts as a double check for pre-labeled charts.
Chart numbering	The number of charts in use must be identified, for example chart 1 of 2. Any additional ancillary charts must also be identified on the main chart. This is to provide an alert to minimise the risk of omission of medicine or inappropriate prescribing.
Allergies and adverse drug reaction alerts	The NIMC includes a section to record the medicine and the reaction, if known. This is to assist prescribing decisions. The ADR section must be clearly visible whenever most prescriptions are written. Red is used to draw attention to this important section.
Once only and nurse initiatied medicines and pre-medications	The NIMC includes a separate section for once only and nurse initiated medicines and pre-medications a to distinguish them from regular medicines and therefore minimise the risk of unnecessary administration. It is important that this section is included on the NIMC rather than a separate chart to minimise the risk of omission and to provide a complete medication history.
Telephone orders	Telephone orders should generally be discouraged, unless they are essential due to work practice restrictions, such as rural and private hospitals and facilities without resident medical staff. Some metropolitan sites have limited telephone orders to one dose, by blacking out the remaining three of the four boxes. Capacity has been allowed on the medication chart for two nurses to sign for a telephone order, which must be co-signed by the prescriber within 24 hours of the order.
Medicines taken prior to presentation to hospital	There should be space on the medication chart to record medicines taken by the patient prior to admission. Some sites may record this information on a separate form which is purpose designed to facilitate reconciliation and accompanies the medication chart. This will assist with the medication reconciliation process on admission, during transfer and at discharge. Where dedicated medication reconciliation forms are used, sites may refer to the alternate form in the 'medicines taken prior to presentation' section. Dedicated medication reconciliation forms must accompany the current medication chart at all times.
Regular medications	**Variable dose section:** The format of this section facilitates ordering of medicines that require variable doses based on pathology results or as a reducing protocol. The medicine level should be entered together with the date. The prescriber's initials, actual administration time and the initials of the person administering the dose must accompany each dose. If a second variable dose medicine is required, or twice daily dosing is appropriate, the regular medicines section should be used following the format for variable dose orders described above. **Warfarin section:** The warfarin section is highlighted in red to indicate that it is a high risk medicine.

	A recommended standard dose time (such as 1600 hours) allows the medical staff responsible for the care of the patient to review the INR (international normalised ratio) result and prescribe the dose, rather than an on-call doctor who may not be familiar with the patient's medical history. This dose time may be modified to a later time for rural or private facilities, where a visiting medical officer cares for the patient. The indication and target INR range must be documented when warfarin is initially ordered. The INR should be documented at a frequency appropriate to the patient's condition. The dose, prescriber's initials, initials of the person administering the warfarin and the initials of the second person checking the administration should also be documented. The NIMC includes a warfarin education record to indicate that the patient has received verbal and written information, as appropriate. **Regular medications section:** Prescribers should enter administration times, as this minimises the risk of errors that may result from incorrect interpretation of the instructions by the nursing staff. In addition to signing the order, prescribers must also print their name at least once and provide contact details, such as pager number or prescriber number, to minimise delays in clarifying orders. Recommended administration times must be listed in the centre margin for easy reference. The suggested administration times may be amended to meet local needs. Health service organisations may find it helpful to ensure that administration times are standardised between wards. A pharmacy box must be included to provide space for pharmacist's annotation An indication box must be included to provide clarity, especially where a medicine may be used for more than one indication. The red 'tick if slow release' box is included as a prompt to prescribers to consider whether a modified release or immediate release preparation is required. The administration record provides space to record up to eleven days of therapy. The last column is partially blocked out to ensure that a new chart is written during the day. Codes for not administering medicines must be listed in the centre of the chart for easy reference. A section for clinical pharmacist review must be included to ensure that all orders are clear, safe and appropriate for that individual patient, to minimise the risk of an adverse drug event.
Patient weight and height	Patient weight and height must be documented to assist staff in calculating doses safely, especially for paediatric patients, and for certain high risk medicines.
Folds	Additional folds risk patient safety by obscuring patient identification and other critical information and do not constitute part of the agreed, standard NIMC.

PRN (as required) medicines	A specific section must be included on the medication chart for PRN (as required) medicines, rather than including them in the regular medicines section, to minimise the risk of these being administered regularly. The prescriber must document the dose and hourly frequency, as 'PRN' does not provide sufficient information for the medicine to be administered correctly. Indication and maximum daily PRN dose (that is, maximum PRN dose in twenty four hours) must be provided to ensure safe and appropriate administration and to minimise the risk of overdose. The prescriber must check the regular medicines section for possible duplicate orders. Where appropriate, the prescriber may indicate the maximum number of doses to be administered or maximum duration for the order by crossing out parts of the administration section. Staff administering the medicine must document the actual dose given. The person administering each dose must check the maximum PRN dose in 24 hours and also check the timing of the previous dose (either PRN or regular).

2. Arrangements and process for NIMC local management

This document provides guidance on the scope of changes to the NIMC which can be authorised at local (state, territory, private and public health service organisation network) levels.

Background

On 23 April 2004, Australian Health Ministers, in a joint communiqué, advised that:

'To reduce the harm to patients from medication errors, by June 2006, all public hospitals will be using a common medication chart. This means that the same chart will be used wherever a doctor or nurse works and wherever the patient is within a hospital'.

The Australian Commission on Safety and Quality in Health Care's Health Service Medication Expert Advisory Group was established in 2007 (originally as the NIMC Oversight Committee) to:

- maintain NIMC national version control
- recommend changes to the NIMC
- identify national impediments to implementation.

Local medication safety groups play a vital role in the process of managing NIMC use locally and recommending issues for the Health Service Medication Expert Advisory Group's consideration.

The Commission has agreed that:

- The NIMC will be updated only when there is a powerful, evidence-based case for change put to the Health Service Medication Expert Advisory Group. The Commission's Inter-Jurisdictional and Private Hospital Sector Committees will advise on timing of the introduction of any changes.
- Specialist and ancillary charts will also be recommended by the Health Service Medication Expert Advisory Group.

Goal

Each jurisdictional NIMC oversight body (or the equivalent arrangement) has the responsibility to respond in a timely manner to NIMC issues raised locally. This document is intended to assist jurisdictional bodies maintain version control of the NIMC by managing issues, such as proposals for change, at the local level or referring issues to the Health Service Medication Expert Advisory Group.

Premises

The work of jurisdictional NIMC oversight bodies is based on the premise that standardisation of practice, where appropriate, can reduce the risk of error. Accordingly, version control of the NIMC is an essential feature of its national implementation. Experience with the paper-based NIMC will be transferred to developments in the electronic environment.

Purpose of the NIMC

The NIMC is a standard inpatient medication chart intended to contribute in different ways to minimising medication errors and adverse outcomes for inpatients.

2a. Managing proposals for change

The following is an agreed process for managing proposals for change to the NIMC.

Stage 1: Collating and classifying proposals for change

Collate and classify suggested changes to the NIMC by:

- maintaining a jurisdictional change register for NIMC change proposals; and
- classifying all suggested changes to the NIMC using the following process.

1. **Does the proposed change comply with the NIMC Local Management Guidelines?**
    - Yes – change is approved by the jurisdictional NIMC body and conveyed to the Health Service Medication Expert Advisory Group for information.
    - No – go to question 2.
2. **Is there local evidence* that there is an issue with the current format and patient safety?**
    - Yes – Go to question 3.
    - No – jurisdictional NIMC body rejects the proposal for change.

    ** Local evidence may comprise risk assessments, case reports, surveys, audits and incident reports.*
3. **Does local evidence suggest that a proposed change will improve patient safety?**
    - Yes – notify the Health Service Medication Advisory Group (for its consideration and possible further evaluation).
    - No – jurisdictional NIMC body rejects the proposal for change.

Stage 2: Reporting to the Health Service Medication Expert Advisory Group

The jurisdictional NIMC body submits a report to the Health Service Medication Expert Advisory Group which includes:

- proposed changes, together with evidence and rationale
- recommendations to approve, reject or further investigate the proposed changes.

Recommendations made by the Health Service Medication Expert Advisory Group will be considered by the Inter-Jurisdictional and Private Hospital Sector Committees and ratified by the Commission before they become effective. Approved changes to the NIMC will be incorporated into the next scheduled version update (usually January of each year).

Step 3: Reporting decisions to stakeholders

- The jurisdictional NIMC body will:
    - Inform stakeholders whether their proposed change has been accepted, rejected or referred to the Health Service Medication Expert Advisory Group, providing a rationale for the decision.
    - Facilitate state-wide change management of proposed changes that have been endorsed by the Office of the Commission for inclusion in the NIMC.
- The Health Service Medication Expert Advisory Group, through the Office of the Commission, will:
    - Inform jurisdictional bodies of Commission decisions, and the rationale for those decisions
    - Provide details of approved revisions in a format that facilitates alignment of national version control and local process control.

2b. Arrangements for jurisdictional NIMC bodies

Membership of jurisdictional NIMC oversight bodies is determined by each jurisdiction. However, to reflect the full, multi-disciplinary medication perspective, the following interests and expertise are suggested for inclusion:

- Health Service Medication Expert Advisory Group jurisdictional representative;
- Representative from a local medication safety program;
- Pharmacist;
- Senior doctor;
- Junior doctor;
- Clinical nurse;
- Clinical risk manager.

It is recommended that rural, regional and metropolitan representation is reflected in memberships.

From time to time, the Health Service Medication Expert Advisory Group invites organisations or individuals with specific issues or proposed changes to its meetings for advice or guidance on specific matters. This may be a useful model for jurisdictional NIMC bodies.

Meetings

It is recommended that jurisdictional NIMC bodies meet sufficiently frequently to assess and report on all suggested changes to the NIMC. The chairman and secretary (or equivalents), in consultation with body members, should determine a calendar of meetings so stakeholders are able to have issues considered in a timely manner. Out of session meetings, either in person or by other means, are recommended should more urgent matters need to be resolved. Terms of reference may assist expediting business.

Reporting arrangements

While each jurisdictional NIMC body reports locally, annual reporting to the Health Service Medication Expert Advisory Group is an important part of national version control. Additional reporting to the Health Service Medication Expert Advisory Group may be determined at the jurisdictional level.

The Health Service Medication Expert Advisory Group maintains a national register of change proposals considered by it on the Australian Commission on Safety and Quality of Health Care web site. The Health Service Medication Expert Advisory Group looks to jurisdictional NIMC bodies for additional information useful to the medication community which can be included on the webpage.

Confidentiality

Documents circulated to jurisdictional NIMC bodies by the Health Service Medication Expert Advisory Group noted as confidential or not for circulation are for the exclusive use of the jurisdictional NIMC bodies and are not to be copied or circulated unless authorisation is provided.

3. NIMC summary rationale

Ensuring patients receive the best therapy in a safe and effective manner is a complex process involving many health professionals often working in teams. One critical component of this process is the communication of medicines orders to allow safe and accurate dispensing, administration and reconciliation of medicines. Evidence suggests that communication can be made safer through education of safe prescribing and administration principles and with standardisation of best practice to reduce the potential for errors.

Additional potential benefits in patient safety are derived from:

- standardisation of best practice throughout the medication management cycle, within and between healthcare organisations
- standardisation of undergraduate, postgraduate and continuing professional education in the medication management cycle.

3a. Key principles for ordering and administering medicines for an individual patient

1. When a medication chart is first written up, the patient's name should always be handwritten at the top of the chart by the prescriber. This acts as a double check for pre-labelled charts and reduces the risk of ordering medicine for the wrong patient.
2. When subsequent new medicine orders are written, the chart should be checked to ensure it is for the correct patient.
3. A medication chart should include a section for recording adverse drug reaction information. This section should enable documentation of whether a reaction has previously occurred, the nature of the reaction (if one has occurred previously), the date the reaction occurred and the signature of the healthcare professional recording the information. If no previous reactions have occurred, this should be explicitly documented (e.g. 'nil known'). If no information is available about previous reactions (e.g. if the patient is unable to communicate), this should also be documented (e.g. 'unknown'). This section should be clearly visible where most regular prescriptions are written to reduce the risk of inadvertent exposure to a drug to which the patient is allergic.
4. A single medication chart should include a section for 'once only' and premedication orders so that they are neither on a separate chart nor included with regular orders. This minimises the risk of doses being missed or orders being continued inadvertently, as well as providing a more complete medication history on a single chart.
5. Telephone orders should be discouraged, unless essential due to work practice restrictions (for example, health service organisations with no resident medical staff). Where telephone orders are unavoidable, the medication chart should contain a section that facilitates the safe practice of two staff independently receiving and reading back the order to the prescriber. These orders should allow no more than four doses to be administered before being signed by the prescriber.
6. There should be a section on the medication chart for recording medicines taken by the patient prior to admission, except when a facility uses a dedicated medication reconciliation chart that accompanies the current medication chart. The inclusion of this information on or with the medication chart, or on a dedicated chart, facilitates reconciliation of pre-admission medicines with medicines prescribed whilst the patient is in care and at transfer. It also aids communication of changes to medicines made during admission to patients and primary care clinicians.
7. A medication chart must include a specific section for prescribing variable doses of medicines. This section should facilitate ordering and documentation of drug levels, as appropriate, to assist selection of suitable subsequent doses. It is recommended that this

variable dose section be on the inside of the chart with other regular orders to reduce the risk of dose omissions.

8. A medication chart should include a specific section for documenting venous thrombo-embolism (VTE) risk, prophylaxis appropriateness, ordering and recording administration of VTE chemo-prophylaxis and ordering and recording checking of mechanical prophylaxis. Hospital-associated VTE is a national safety and quality issue with research showing that medication chart prompts can improve the rate of VTE risk assessment and of appropriate prophylaxis prescribing.
9. A medication chart should include a specific section for prescribing warfarin. Warfarin is associated with adverse events both through under-dosing and overdosing. The warfarin section should enable documentation of both the International Normalised Ration (INR) target range and INR results to facilitate dosing decisions. Ideally, warfarin should be administered at 4 p.m. to ensure morning results are reviewed and the next dose is ordered by a prescriber familiar with the patient's medication management, rather than by 'after-hours' medical staff.
10. A medication chart should have a separate section for 'when required' (PRN) medicines in order to distinguish them from medicines that need to be given regularly. The PRN orders should be unambiguous, with clearly defined doses or dose ranges, minimum hourly frequency of administration and a recommended maximum dose in 24 hours, together with the indication for use.
11. A medication chart should include a specific section for nurse-initiated medicine, in accordance with state regulations and local practices.
12. Medicine orders should be dated from when the medication chart is rewritten, although medication management review is aided by documenting the date the medicine is started. It is useful to record in the National Medication Management Plan when medicines were commenced.
13. The chart should encourage prescribing using generic (active ingredient) medicine names. This is to reduce the risk of duplicate orders of the same medicine being made because of unfamiliarity with different trade (brand) names. In addition, medicines are usually stocked on the ward alphabetically by generic name, therefore generic prescribing facilitates location of the drug.
14. The chart should discourage the use of abbreviations, particularly those known to be error-prone. This reduces the risk of misinterpretation. Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines should be reflected in local health service organisation policy.
15. The chart should facilitate recording of the administration times by the prescriber, based on a locally agreed standard. This reduces the potential for nurses to misinterpret prescribed administration frequency instructions.
16. The chart should include a section for clinical pharmacist annotation regarding supply and administration. In addition, a section enabling pharmacists to sign the chart following review by a pharmacist facilitates peer review and improves communication with pharmacists covering the same ward or unit.
17. The chart should facilitate dispensing of discharge medicine directly from the medication chart, to avoid transcription errors. This may not be applicable for those sites using the PBS for discharge medicines or where separate discharge prescriptions are used. In such cases, local procedures should be developed to ensure that transcription errors are minimised and full medication reconciliation at discharge is facilitated.
18. The chart should include a section for prescriber contact details (for example, pager number), so that they can be easily contacted.

4. NIMC versions

The NIMC is a suite of standard medication charts in both paper-based and electronic formats. Use of the NIMC is mandatory and can be demonstrated by implementation and use of one, or more, of the following NIMC versions. Charts are available in formats designed for private health services.

All versions of the NIMC are available from the Commission web site in low and high resolution PDF files and in design files.

1. NIMC (acute care)

The NIMC (acute care) is a medication chart designed for patients in acute care. It is used across health service organisations in medical and surgical wards, emergency departments and intensive care units. The NIMC (acute) available on the Commission web site has 10.5 days of administration although the number of administration days may be varied locally.

2. NIMC (long-stay)

The NIMC (long-stay) is designed for long-term, stable adult patients in acute care. For example, the NIMC (long-stay) may be suitable for patients in spinal units and rehabilitation units. The NIMC (long-stay) available on the Commission web site has 28.5 days of administration although the number of administration days may be varied locally.

3. NIMC (paediatric) and NIMC (paediatric long stay)

In 2008, Australian Health Ministers endorsed paediatric versions of the NIMC (acute) and NIMC (long stay). The paediatric NIMCs have additional features for safe prescribing in paediatric patients including neonates. These charts should be used for all children aged 12 years and less.

Use of the safety features specific to the paediatric NIMCs is outlined in Section 7 of this guide. Unless otherwise indicated, all other guidance in this document is relevant to the paediatric NIMCs.

4. NIMC in private health service organisations

Private health service organisations often face a unique challenge in relation to safe medication charting. The Pharmaceutical Benefits Scheme requires separate, signed prescriptions for each medication order and pharmacy arrangements often require separate paper-based orders for dispensing. Private health service organisation versions of the NIMCs include the same design and safety features but incorporate tear away sections for pharmacy orders and Medicare Australia claiming purposes.

5. NIMC (GP e-version)

General practitioners who prescribe for inpatients (usually in rural and remote health service organisations) need to issue medicine orders in NIMC compliant formats. To accommodate this requirement, the NIMC (GP e-version), a four A4 page version, was developed for incorporation in general practice electronic prescribing software. This allows general practitioners to print out medicine orders for inpatients in the NIMC (acute) format and permits recording of inpatient medicines administration using the standard NIMC process. Additional advice on use of the NIMC (e-version) forms Attachment D to this guide.

6. NIMC (day surgery)
The NIMC (day surgery) is a two-side A4 medication chart which has no regular medicine order spaces. It incorporates standard NIMC features as well as features suitable for day procedure services: • IV fluid administration • VTE risk assessment section without prophylaxis ordering
7. NIMC (clozapine titration)
NIMC (clozapine titration) is intended to be used as a record of the prescribing, monitoring and administration of clozapine titration for adult patients. It is used in conjunction with the NIMC (acute) or NIMC (long-stay) or the private health service organisation versions of them. When clozapine is used for maintenance treatment, the NIMC (acute) or NIMC (long-stay) or private health service organisation versions should be used. Guidance on the use of the NIMC (clozapine titration) is available in a separate document to the NIMC User Guide. A private health service organisation version of the NIMC (clozapine titration) is expected to be available in late 2013.
8. NIMC (subcutaneous insulin)
In May 2013, a national subcutaneous insulin chart was being piloted by health service organisations nationally and was expected to be mandated for use in 2014. The chart combines Blood Glucose Level recording and monitoring with insulin ordering and recording of administration. During the implementation phase, guidance on use of the NIMC (subcutaneous insulin) will be available in a separate document to the NIMC User Guide.

In addition, there are standard documents for recording medicines administration and medication history.

9. National Interim Residential Medication Administration Chart
The National Interim Residential Medication Administration Chart is designed for residential aged care facilities to record administration of discharge medicines accompanying residents returning from hospital.
10. National Medication Management Plan
The national Medication Management Plan (MMP) provides health service organisations with a standardised form that can be used by nursing, medical, pharmacy and allied health staff to improve the accuracy of information recorded on admission and available to the clinician responsible for therapeutic decision making. A standardised form to record the medicines taken prior to presentation at the health service organisation and used for reconciling patients' medicines on admission, intra-health service transfer and at discharge is considered essential for the medication reconciliation process. The national MMP provides Australian health service organisations with a form designed specifically for these purposes The national MMP is designed for use in adult and paediatric patients.

Appendix 1

Version control

DATE	VERSION	SUMMARY OF VERSION	AUTHOR
07/02/07	1.0	Stepped process for managing local issues and incorporating rationale and permitted local variations to NIMC.	G. Bedford
06/12/10	1.1	Incorporating new binding location instructions. Change references to NIMC Oversight Committee to Health Service Medication Expert Advisory Group.	G. Bedford
06/06/13	1.2	Reorder sections, reflect amended Summary Rationale, replace medication with medicine as appropriate, include section on NIMC versions	G. Bedford